Statement of Congressman Peter Roskam
Joint Subcommittee Hearing on Reducing Fraud, Waste and Abuse in Medicare

June 15, 2010

Chairmen Lewis and Stark, Ranking Members Boustany and Herger, and fellow Members of the Oversight and Health Subcommittees, thank you for holding this important, fact-finding hearing on reducing fraud, waste and abuse in the Medicare program. I look forward to hearing different proposals and ongoing efforts to reduce fraud, which I believe is a bipartisan problem that infuriates taxpayers and Members of Congress alike. As a guardian of taxpayer dollars and the Medicare program, I feel the duty to offer an innovative solution to mitigate fraud in Medicare.

HIPAA defined healthcare fraud as any scheme to obtain payment by means of misrepresentation from any healthcare benefit program. Fraud plagues both private and public programs, but Medicare is especially vulnerable to fraudsters ranging from petty thieves to organized crime. Since 1990, GAO has annually declared Medicare at high risk for improper payments and fraud due to its size, scope and decentralized administrative structure. Fraud robs tens of billions of taxpayer dollars from the Medicare system without any benefit to seniors.

One major problem is the lack of accurate measurement of Medicare fraud. Estimates vary widely, and reliable estimates of actual dollar value lost to Medicare fraud are limited. The Washington Post, 60 Minutes, ABC World News, the Wall Street Journal, National Public Radio, and many other media outlets have reported about fake patients, deceased doctors, fly-by-night storefronts, and multi-state criminal rings bilking $60 billion or more annually from seniors and taxpayers. The FBI estimates that healthcare fraud accounts for up to 10 percent of total health spending, or up to $250 billion per year. Thomson Reuters estimates healthcare fraud and abuse accounts for $125 to $175 billion per year. The Administration reports 7.8 percent or over $24 billion in improper payments in Medicare fee-for-service, but this metric measures over-payments and under-payments and not fraud. Last week, President Obama announced an initiative to slash Medicare fraud in half by 2012, but the metrics for the measurement change too often to get a firm estimate.

One fraudster particularly grabbed my attention - Miguel Luis Perez, who the FBI described as an "international traveler." Born in Cuba, Mr. Perez submitted more than $179 million in Medicare claims and received over $56 million from Medicare before fleeing the country. I introduced the Committee to Mr. Perez's narrative last summer in the early hours of the morning during the markup of an early iteration of the healthcare bill, HR 3200. Simultaneously, I offered an amendment to move the way Medicare verifies claims from current policy towards the way the financial services industry verifies purchases – more diligence before payments are made to remedy our current "pay and chase" pursuit of fraudsters. My goal was to catch fraudsters like Mr. Perez before he can take millions of taxpayer dollars and hop on a flight out of the country. I am happy to report that Mexico's immigration service turned over Mr. Perez to the FBI

earlier this year. However, there have been sixty criminals similar to Mr. Perez, who have been indicted for Medicare fraud but fled the country over the past five years.

Fraud may be pervasive in areas like South Florida, but it is prevalent everywhere. Last year, two individuals in my Congressional District who submitted more than $5 million in claims and received more than $1.8 million in reimbursement from Medicare were indicted for Medicare fraud. In this case, between February 2005 and May 2006, approximately 99 percent of the claims submitted were for power wheelchairs and accessories that were never supplied according to the FBI Chicago Bureau. Also in Illinois, a podiatrist, hospital, and ambulance service provider were all identified in HHS and DoJ's most recent Health Care Fraud and Abuse Control Program Annual Report. These fraudsters continue to be one step ahead of our current rules- and edits-based automated claims processing.

My amendment has been developed and modified since last summer. I introduced it as an amendment to the Rules Committee in November before the House considered the healthcare bill last fall. I spoke with Nancy-Ann DeParle over the phone and she displayed interest in the proposal. President Obama then included the amendment in his health outline. Secretary Sebelius and Senate Finance Chairman Baucus have also expressed interest in the concept. Over the past year, I have met with experts in healthcare fraud mitigation and modified my ideas into legislation I will introduce today. I believe it will both measure the amount of Medicare fraud more accurately and protect the Medicare trust fund from billions of dollars in fraud.

My legislation would reform the way Medicare pays claims by directing the Centers for Medicare and Medicaid Services (CMS) Office of Program Integrity to design a comprehensive pre-payment predictive modeling system to be applied prior to reimbursing claims, preventing improper payments from being made. Strengthening claims at the front end of the payment system will prevent suspect claims from being reimbursed. CMS currently uses a limited application of pre-payment screening, editing and selective review of claims conducted by Medicare Administrative Contractors (MACs). Most resources are utilized on post-payment review activities by Zone Program Integrity Contractors (ZPICs) and Recovery Audit Contractors (RACs). Predictive modeling can detect fraudulent claims that traditional rule-based edits cannot identify. CMS is currently developing an integrated data repository that will eventually contain all provider data that can be mined, but this will still be post-payment pursuit of fraud.

Predictive modeling "scores" a claim to identify claims that have a high probability of fraud. A predictive model creates an estimated score on claims using historical data. That estimate is then applied to new claims that are submitted. The predictive model is always evolving, improving and adapting to provider and patient behavior. Highly suspicious claims are subject to manual review to avoid false-positives and a provider self-audit appeal process. Following successful implementation to the Medicare program, the predictive modeling system could be developed for all Federal Health Programs like Medicaid and CHIP.

Predictive modeling is a process used in analytics to create a statistical model of future behavior that is used in industries such as financial services, direct mail, utility companies and retail for multiple applications including probability scoring assessments. Predictive modeling was utilized by the financial services industry in the early 1990s to model consumer behavior. Initially, there was a cultural resistance to implement predictive modeling throughout the industry. However, within five years, 80 percent of financial services institutions had implemented predictive modeling. Fraudsters were flocking to institutions that had not adapted a predictive modeling strategy. The industry, which handles $11 trillion in transactions yearly, suffers only .047 percent in fraud thanks to a predictive modeling system that stops fraud and abuse at the point of sale.

The Lewin Group conservatively estimates that a comprehensive application of predictive modeling can save Medicare $65 billion. Another analysis by TerraMedica, a healthcare technology firm, finds between $18.6 billion and $42.2 billion in annual suspicious claims that could be subject to fraud, abuse or overutilization patterns. In 2009, Medicare was able to recover $2.5 billion in improper payments, so predictive modeling could dramatically increase the amount of fraudulent payments detected and savings to the Medicare Trust Fund. Pre-payment predictive modeling would mitigate fraud and deter future criminals from attempting to defraud taxpayer dollars and strengthen the Medicare program for seniors.

Again, thank you for the opportunity to testify before the Committee today. I look forward to any questions.